National Advisory Group for Clinical Audit & Enquiries

Consultation on Future of Audit staff in Trusts

Responses to the overall document and to the specific questions should be sent to clinicalaudit@dh.gsi.gov.uk) by Monday 17 September 2012.

The full document can be downloaded from www.dh.gov.uk/health/2012/07/audit-staff/

Q1	Do you agree with this assessment of the current concerns of audit staff in Trust?]	1. Too many demands: The clinical audit staff I speak to undoubtedly feel that they are now overwhelmed with work not all of which is clinical audit and this abuse of clinical audit staff must be addressed if progress is going to be made at a more local level. 2. I agree that as a result of Trusts having to make significant savings post remain unfilled and clinical audit is an easy target in terms of saving salaries. Obviously the long term implications are significant 3. I think the response to this concern will vary from Trust to Trust. I think that a lot of Trusts will support clinical audit as far as that is possible but as stated already increasing demands from other sources such as CQUIN has deflected activity away from clinically driven projects 4. There does need to be a much more rigorous process for clinical audit departments to vet projects in the annual forward plans that most clinical audit departments work to. Although clinicians must be integral to decision making I believe clinical audit staff should have a greater say on which audits offer the best value and have the greatest chance of succeeding 5. Insufficient ownership and engagement by clinicians remains a problem as many do not have this as a contractual requirement and other tasks often take precedent. This should be tackled in more rigorous job planning and is less of an issue for clinical audit departments 6. I agree with the concerns expressed that other tasks are also a problem for clinical audit departments as well as clinicians. Again stronger management within clinical audit will allow departments to regulate what they do to

		a greater extent.
Q2	Do you agree that the current situation is not sustainable?	The current position for most departments is unsustainable as enough resources simply don't exist. They were not factored into departmental funding when clinical audit was initially considered an essential element of what clinicians and providers of healthcare should be doing to ensure high quality services. It is now a matter of priority setting and perhaps alleviating the burden of some national clinical audits that add little to local quality of care or are simply data collection exercises. Better national priority setting would help
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	There is little doubt in my mind that the proliferation of targets, quality standards, confidential enquires, national clinical audits (a huge number) and CQUINs have resulted in a blurring of the boundaries between data acquisition and clinical audit. Of course all these elements of activity are relevant to the quality of patient care and so there is a very good argument for combining the different strands of activity under "one roof". In other words every Trust should have a department within clinical governance that deals with all these issues including robust clinical audit. Not every trust will be able to recruit the expertise to effectively analyse all hospital activity but organisations already exist to do this and regions have Quality Observatories. In my view all Trusts should work closely with the Regional Quality Observatory utilising their expertise in analysis etc whilst concentrating on high quality clinical audit to answer the questions raised by variance in clinical outcomes.
Q4	Do you agree this would be helpful?	The short answer is yes. Measuring quality and then being unable to influence change would seem an illogical state of affairs in industry. Combining resources to both measure quality and influence change would undoubtedly raise the departments profile and add new impetus to clinical governance and commitment to continuous improvement. It is clinical outcomes and not just targets that are important
Q5	Do you agree this would be helpful?	Agree. There are multiple approaches to quality improvement but there must be some priority setting that ensures Trusts put clinical outcomes before targets or other less clinically

		focussed measures.
Q6	Do you agree this would be helpful?	Again this seems eminently sensible although I do have some reservations about some non-clinical aspects of care which might divert resources into process resign rather than measuring and improving patient outcomes. Obviously patient experience is influenced by having better systems and processes in place but I suspect an entire department could be tied up doing such work to the detriment of the clinical audit
Q7	Do you agree this would be helpful?	Yes
Q8	Do you agree this would be helpful?	Again, the notion of more local or regionally led audit has great appeal when considering the value of clinical audit to individual Trusts and their patients. The danger is that too many "masters" will exist and that each will have their own set of priorities. Cross specialty clinical audit is always challenging, as is cross boundary audit but if progress is to be made both are important aspects of improving pathways of care. Clinical Audit is of course not confined to doctors and the term clinician applies to all healthcare professionals, all of whom should be interested in improving patient care in their particular area
Q9	What is your view of each component in the proposal?	1. All four bullet points are relevant to the debate regarding the future of clinical audit in NHS organisations. It is vital that managers and clinicians sing from the same hymn sheet and that clinicans in particular involve themselves more in managing clinical services 2. Quality departments or "Observatories" should embrace all aspects of quality of care but perhaps limit their work in areas such as analysis of datasets which are already performed by external organisations able to supply such information more easily. Similarly Trusts should tap into the expertise of Regional Quality Observatories and not replicate such work at Trust level. I think it is very important that Trusts utilise as much of the expertise that already exists rather than reinvent the wheel. The executive Board member responsible to the Board should be the MD for medical audits, the Director of Nursing for nursing

		audits and a non-executive director for AHPs and other healthcare groups 3. Training is absolutely essential both for clinical audit staff but also clinicians 4. A regionally led clinical audit forum should be established to achieve multi Trust initiatives and sharing of best practice. This will need regional support and is something closely aligned to the work of the regional quality observatories. In the NE of England NEQOS would have a pivotal role in monitoring and analysing data from all the NE hospital Trusts in order to identify where unacceptable variance exists. Multi Trust clinical audit would then be the tool to find out why such variance exists. 5. My main concern about national audit is that not only is the task huge when it comes to dissemination of information but ensuring changes result from this is even more difficult. Good Trusts will change but many Trusts will have a significant amount of work to do without much benefit as they are already performing at a high level. Re audits are sometimes too frequent as changes take time and those changes are out of the control of the organisation undertaking the audit
Q10	Do you have suggestions for other components?	Reinvigorating clinical audit in times of cutbacks and restraint will be a major challenge but one which could have long term benefits to all healthcare providers. At present the problems are clearly highlighted by this consultation document. The solutions are also in the document but high level backing is now required to implement the changes needed